MBCHP Visit Form – Part 1 of 2

Site Name: _____

Please check one: □ Routine Screening □ Short -Term Follow-Up Provider Name_____

- Please send Part 1 immediately following the office visit and send Part 2 when test results are available.
- Be sure to use a new Part 1 Visit Form every time the client returns for a Routine Screening or Short Term Follow-Up Office Visit
- By checking an abnormal result you are indicating that immediate consultation or diagnostic work-up is needed. The results of the work-up must be documented on a separate Abnormal Follow-up Form that the MBCHP will mail to you.

Name:_____ DOB: __ __ / __ __ / __ __ __ __
(Last Name, First Name, Middle Initial)

Social Security Number or "A" Number_____ Date of this visit: __ __ / __ __ / __ __ __ __

CLINICAL BREAST EXAM

Clinical Breast Exam (CBE) not performed at this visit – reason:

- □ Unable due to clinical/medical reason (CBE due date: __ __ / __ __ / __ __ __ __)
- □ Patient refused
- □ Discussed but not needed this visit (CBE due date: __ __ / __ __ / __ __ __ __)

If exam not done, skip to Mammogram Scheduling section.

Is the client reporting any breast symptoms? □ Yes □ No

If yes, type of symptom_____

CBE Results:

- □ Negative Findings
- □ Benign Findings (such as fibrocystic changes, diffuse lumpiness or nodularity)
- □ Discrete Palpable Mass not suspicious for cancer (i.e., previously worked-up or determined benign)
- □ *Abnormal Exam:
  - □ Nipple or Areolar Scaliness or Discharge
  - □ Skin Dimpling or Retraction
  - □ Discrete Palpable Mass suspicious for cancer (i.e., cystic or solid masses that have not been evaluated beyond mammography)

Plan:

- □ Next routine screening due __ __ / __ __ / __ __ __ __
- □ Short-Term Follow-Up is recommended and will be due __ __ / __ __ / __ __ __ __
- □ *Immediate consultation/diagnostic testing. Referral Provider & Date:_____
  (MBCHP will send an Abnormal Follow-Up Form to complete for this client) (Referral Provider's Name and Appointment Date)

MAMMOGRAM SCHEDULING

Mammogram not ordered at this visit – reason:

- □ Unable due to clinical/medical reason (Mammogram due date: __ __ / __ __ / __ __ __ __)
- □ Patient refused
- □ Discussed but not needed this visit (Mammogram due date: __ __ / __ __ / __ __ __ __)

If mammogram not ordered this visit, skip to Pelvic Exam section.

Mammogram scheduled date: __ __ / __ __ / __ __ __ __ at _____
(Name of Mammography Facility)

PELVIC EXAM

Pelvic Exam not performed at this visit – reason:

- □ Unable due to clinical/medical reason (Pelvic due date: __ __ / __ __ / __ __ __ __)
- □ Patient refused
- □ Discussed but not needed this visit (Pelvic due date: __ __ / __ __ / __ __ __ __)

Pelvic Exam Results and Plan:

- □ Cervix normal on exam, next routine screening due __ __ / __ __ / __ __ __ __
- □ Cervical abnormality detected – Immediate consultation/diagnostic testing
  Referral Provider & Date:_____
  (Referral Provider's Name and Appointment Date)
  (MBCHP will send an Abnormal Follow-Up Form to complete for this client)

(If this is a non-cervical abnormality or the client has no cervix, the MBCHP cannot cover diagnostic services)

Complete only if Client has had Hysterectomy:

- □ Patient had complete hysterectomy for benign condition (cervix absent).*
- □ Patient had supracervical hysterectomy for benign condition (cervix present).
- □ Patient had hysterectomy for cervical neoplasia (cancer).

*Pap testing is not indicated.

PAP SMEAR

Pap Smear not performed at this visit – reason:

- □ Not done because patient had complete hysterectomy for benign condition
- □ Unable due to other clinical/medical reason (Pap smear due date: __ __ / __ __ / __ __ __ __)
- □ Patient refused
- □ Discussed but not needed this visit (Pap smear due date: __ __ / __ __ / __ __ __ __)

Pap smear performed this visit? □ Yes □ No If yes, please complete Visit Form - Part 2.

Specimen Type for Pap Smear:

- □ Conventional smear
- □ Liquid based

MBCHP Visit Form – Part 2 of 2

Site Name: _____

Please submit Part 2 immediately after test results have been received. Provider Name:_____

- Send Part 2 when Pap or Mammogram test results are available. Send Part 1 immediately following the office visit.
- If results are pending at this time, please update this form with additional information when received and resubmit it to the MBCHP.
- By checking an abnormal result you are indicating that immediate consultation or diagnostic work-up is needed. The results of the work-up must be documented on a separate Abnormal Follow-up Form that the MBCHP will mail to you.

Name:_____ DOB: __ __ / __ __ / __ __ __ __
(Last Name, First Name, Middle Initial)

Social Security Number or "A" Number_____ Date of office visit: __ __ / __ __ / __ __ __ __

PAP SMEAR RESULTS

Cytology Laboratory:_____

Please check one: □ Routine Screening
□ Short -Term Follow-Up

Date of Pap:_____

Pap Specimen Type:
□ Conventional smear
□ Liquid based
□ Other

Pap Smear Adequacy:
□ Satisfactory
□ Satisfactory but limited (Bethesda 1991 only)
□ Unsatisfactory

Pap Smear Results Reported in Bethesda 2001 (Preferred):

□ Negative for intraepithelial lesion or malignancy
□ Atypical squamous cells of undetermined significance (ASC-US)
□ Low grade SIL (including HPV changes)
□ *Atypical squamous cells cannot exclude HSIL (ASC-H)
□ *High grade SIL (with features suspicious for invasion)
□ *Squamous Cell Carcinoma
□ *Abnormal Glandular Cells (including Atypical, Endocervical Adenocarcinoma in situ and Adenocarcinoma)
□ Other (specify: _____)

Pap Smear Results Reported in Bethesda 1991:

□ Negative (within normal limits)
□ Infection/ Inflammation/ Reactive Changes
□ Atypical squamous cells of undetermined significance (ASCUS)
□ Low grade SIL (including HPV changes)
□ *High grade SIL
□ *Squamous Cell Cancer
□ *Abnormal Glandular Cells (including AGUS and Adenocarcinoma)
□ Other (specify: _____)
□ Unsatisfactory

Plan:

□ Next routine screening due __ __ / __ __ / __ __ __ __
□ Short-Term Follow-Up is recommended and will be due __ __ / __ __ / __ __ __ __
□ *Immediate consultation/diagnostic testing. Referral Provider & Date:_____
(MBCHP will send an Abnormal Follow-Up Form to complete for this client) (Referral Provider's Name)
_____
(Appointment Date)

□ **Request MBCHP Case Management (for assistance in managing patient care)**

MAMMOGRAM RESULTS

Mammography Facility:_____

Please check one: □ Routine Screening
□ Short -Term Follow-Up
□ Client was "No Show" for Mammogram

Date of Mammogram:_____

If so, was patient also seen in office? Yes □ No □

If so, rescheduled for __ __ / __ __ / __ __ __ __

Mammogram Results:

□ *Assessment Incomplete/Additional Imaging evaluation needed (please include results of additional views, if known)
Results of any additional views:_____
□ Negative
□ Benign Findings
□ Probably Benign – short interval follow-up suggested
□ *Abnormal Exam:
□ Suspicious Abnormality, biopsy should be considered
□ Highly Suggestive of Malignancy

Plan:

□ Next routine screening due __ __ / __ __ / __ __ __ __
□ Short-Term Follow-Up is recommended and will be due __ __ / __ __ / __ __ __ __
□ *Immediate consultation/diagnostic testing. Referral Provider & Date:_____
(MBCHP will send an Abnormal Follow-Up Form to complete for this client) (Referral Provider's Name)
_____
(Appointment Date)

□ **Request MBCHP Case Management (for assistance in managing patient care)**

Please return this form to: MBCHP, 11 State House Station, Augusta, ME 04333, Phone: 1-800-350-5180, Fax: 1-800-325-5760 [Rev 9/02]